CarePoint Health Plans

GET THE MOST OUT OF YOUR

CAREPOINT ADVANTAGE HEALTH PLAN

www.carepointadvantage.org (855) 593-5757

Selecting a health insurance plan can be a daunting task, especially if you are eligible for Medicare.

It seems that the rules and regulations are endless and complex. In addition, the information in media and news reports may conflict and add to the confusion. It shouldn't be this difficult to simply take care of your own health care needs. That is why CarePoint has created CarePoint Health Medicare Advantage (CarePoint Advantage), an easy-to-use, straightforward plan to cover all of your Medicare health insurance needs.

CarePoint Health believes that everyone deserves high-quality health care provided by dedicated medical professionals. Our approach provides preventive health care up front, as well as interventional care should you become ill or injured.

We believe in keeping you healthy and providing for your needs should you become ill. From top to bottom, CarePoint wants to be sure that you are taken care of.

An overview of Medicare Advantage plans

Medicare Advantage health plans

Medicare Advantage health plans are for those people either already enrolled in Medicare or who are eligible to do so. All Medicare Advantage plans offer, at a minimum, the same rights, benefits, and protections as traditional Medicare Parts A and B. Advantage plans have limits on out-of-pocket expenses paid by you, and once you reach the limit, you pay nothing for most additional covered services. However, the limit may change from year to year, thus it is important that you review your policy annually for any changes. An Advantage plan also may not charge more than traditional Medicare for services such as chemotherapy, dialysis, or skilled nursing facility care.

For all Medicare Advantage plans, you must enroll during specific times of the year. These are:

- Open enrollment — Between October 15th and December 7th
- Three months before you become eligible (for many, at the age of 65)
- The month you become eligible
- Within three months after becoming eligible

You are still eligible if you have a pre-existing condition with the exception of those with End-Stage Renal Disease (ESRD). Unfortunately, those with ESRD are typically eligible only for traditional Medicare.

CarePoint Health Medicare Advantage

In addition to providing all of the same coverage and benefits as traditional Medicare Parts A and B, CarePoint Advantage also includes Part D, or prescription drug coverage. CarePoint Advantage is available to eligible residents of Hudson County, and is offered as a PPO (preferred provider organization) health plan. With CarePoint Advantage, you have access to a large network of physicians, hospitals, and other health care providers, allowing you a significant amount of freedom in directing your own care. You also have the benefit of $0 co-pays for in-network Medicare-covered doctor's appointments and the ability to go out-of-network without obtaining referrals first. Using in-network providers is typically hassle-free with no referrals to see specialists and very little paperwork to complete for any of your care.

CarePoint Advantage compared to traditional Medicare

CarePoint Advantage combines traditional Medicare and prescription drug coverage into one single plan with the benefit of additional perks, benefits, and coverage.

All Medicare plans, whether traditional (Parts A and B) or Advantage (Part C) must offer the same minimum coverage to all eligible people. However, few understand what each part actually covers and how Advantage plans may be different.

Medicare Part A

Medicare Part A is one half of what is considered traditional Medicare. It primarily covers inpatient hospital stays and the services involved in such stays. This includes any meals, supplies, testing, and physician services during the stay. Those with Medicare Part A may or may not have a monthly premium depending on how long they or their spouse worked and paid Medicare taxes.

Medicare Part B

Medicare Part B is the voluntary half of traditional Medicare and covers outpatient medical care and services. This includes observation hospital stays but has very different rules about coverage than Part A coverage for inpatient stays. Part B covers 80% of outpatient hospitalization and a portion of each individual service during the outpatient stay. It also covers many other outpatient visits, although there may be co-pays and premiums depending on the services sought. Part B coverage requires payment of a monthly premium regardless of Medicare taxes paid while working. In addition, an annual deductible must be met before Part B coverage begins; however, if you have health spending plan flex dollars, these may be used towards the deductible and any co-pays.

Medicare Part C

Medicare Part C is more commonly known as Advantage. Advantage plans, including CarePoint Advantage, are those offered by private insurance companies with the approval of the Centers for Medicare and Medicaid Services (CMS). Advantage plans must offer, at a minimum, all of the same benefits and coverages as traditional Part A and Part B. Many Advantage plans, CarePoint Advantage included, offer prescription drug coverage as one of the plan's benefits while traditional Medicare offers it as add-on coverage. Medicare Advantage plans usually offer many benefits and services not covered by traditional Medicare.

Medicare Part D

Medicare Part D is voluntary coverage to supplement Medicare Parts A and B and covers prescription drugs. Part D plans are administered by private, CMS-approved insurance companies. It is important to understand that even with Part D coverage, patients may still have co-payments for their prescription medications.

CarePoint Advantage compared to Medicare Parts A and B

CarePoint Health Medicare Advantage is a Medicare Part C plan. It includes all of the same benefits of traditional Medicare as well as many other advantages. With CarePoint Advantage, you may see any doctor or go to any hospital. The plan is a PPO, and you have a large network of in-plan providers to choose from, as well as the ability to see out-of-network providers if you so choose (although out-of-network providers require a higher co-pay). Just a few of the many benefits of CarePoint Health Medicare Advantage include:

- All of the benefits of traditional Medicare
- The ability to see any doctor, go to any hospital, or see any provider
- $0 monthly premiums (although, if you have Medicare Part B, you will still need to pay your Part B premiums)
- $0 for all in-network Medicare-covered primary care visits
- $0 generic prescriptions from retail pharmacies or mail-order services
- $0 in-network annual vision exam
- One pair of eyeglasses or set of contacts annually, up to $100
- Coverage for over-the-counter medications purchased with a prescription
- Up to $70 per quarter towards supplemental over-the-counter items

Your insurance plan — understand the basics and take advantage of everything it has to offer

Whether you have traditional Medicare or CarePoint Health Medicare Advantage, it is important to understand your plan and learn how to take full advantage of everything the plan has to offer.

Understand the basics

Understanding the basics of your insurance plan will allow you to get the best use of out of your health care coverage. Your plan should provide you with plenty of information regarding what services and supplies are covered, what your out-of-pocket expenses will be, what doctors or facilities are covered, and what else is included in the plan's coverage on top of those things covered by traditional Medicare. For example, does the plan offer any coverage for prescription drugs or vision care? CarePoint Advantage offers benefits for both prescription drugs and vision care.

When considering your plan's coverage, be sure that any chronic health conditions you suffer from are covered and that you can see the doctors and get the medications and supplies you need. A plan like CarePoint Advantage offers the benefit of no restrictions on doctors and offers a significant amount of coverage for medications and other services. Be sure to understand what you will be responsible for in terms of co-pays, deductibles, premiums, and so on.

When shopping for your insurance plan, spend time comparing your options and choose the plan that provides you with the best possible coverage for your needs. If you wish to continue using your current doctor, specialists, and medical facilities, be sure they are in-network or covered by your preferred health insurance plan. If you travel, either domestically or internationally, you will also want to know if you will be covered when away from home. CarePoint allows you to see any doctor and go to any hospital; what you pay out-of-pocket will depend on whether or not the providers and facilities are in-network.

Read your plan's summary plan description

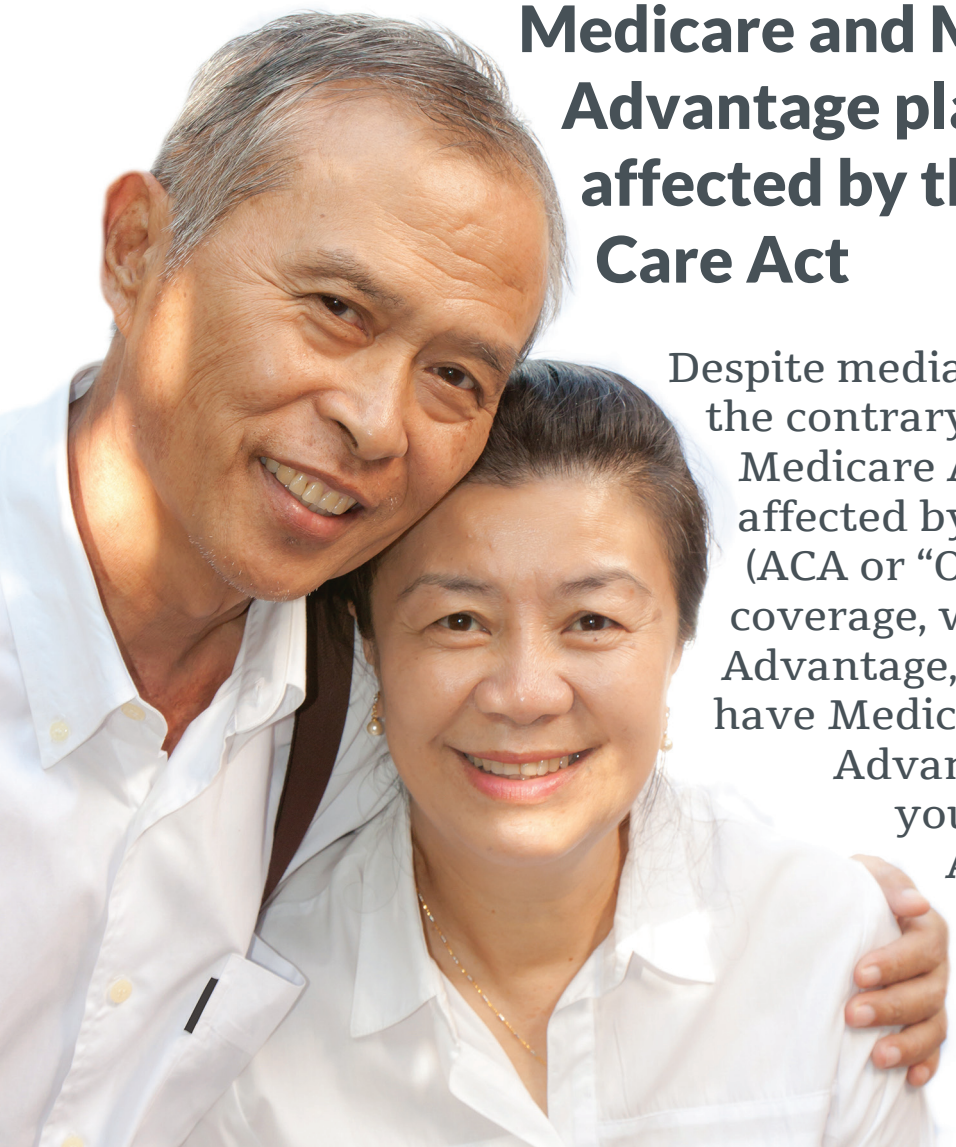
You are entitled to a copy of your chosen health plan's summary plan description (SPD), a document outlining your benefits and rights under the plan, and you have a right to ask questions about anything in the SPD. The description should outline your overall benefits, co-payments and costs for which you will be responsible, and circumstances under which your plan may be terminated or your benefits may be changed. Your health benefits and rights are protected by the federal Employee Retirement Income Security Act (ERISA).

Understand your responsibilities and rights if you need to change your coverage

In general, the only acceptable time to change your insurance coverage is during open enrollment, unless you have a qualifying life-changing event. For example, if you get married, get divorced, or your spouse passes away, you have the right to change your insurance coverage at the time of the event. It is also important to understand how your insurance plan, whether traditional Medicare, an Advantage plan, or some other form of insurance, is affected if you or your spouse also has insurance through other means such as an employer. Your ability to obtain your own health plan may be impacted by your spouse's coverage. Certain rights to change your insurance benefits outside of the open enrollment period are protected by the Health Insurance Portability and Accountability Act (HIPAA) — the same law that protects your privacy and medical records.

Understand your rights if a health benefits claim is denied

Unfortunately, sometimes health plans deny claims and refuse to cover a doctor's visit or other care. This may simply be due to a clerical error, or perhaps other documentation needs to be submitted to support the initial claim. Whatever the reason, you have a right to appeal if you believe that your insurance should have covered the services that the plan has denied. If you have such a situation, be sure to keep any documents, copies of correspondence, or any other items or materials related to the denial and your appeal. Your plan's summary plan description should list details regarding how to file an appeal, including who to contact for assistance.



Medicare and Medicare Advantage plans are not affected by the Affordable Care Act

Despite media claims and rumors to the contrary, no Medicare or Medicare Advantage plan is affected by the Affordable Care Act (ACA or "Obamacare"). Medicare coverage, whether traditional or Advantage, is fully separate. If you have Medicare or Medicare Advantage health coverage, you do not qualify for an ACA marketplace plan.

Open enrollment is the best time to enroll in your preferred plan

Medicare open enrollment, including enrollment for traditional Medicare, Medicare Advantage (like CarePoint Advantage), or Medicare Part D, is from October 15th to December 7th. Your preferred plan's benefits will then begin on January 1st. The primary exception is if you become eligible (usually by turning 65 years of age) outside of the open enrollment period.

Failing to enroll during either open enrollment or your initial eligibility period may result in a fine or penalty. During open enrollment, you may change from one Medicare plan to another, including Medicare Advantage. If you have Medicare Advantage and feel the need to revert to traditional Medicare, you may do so between January 1st and February 14th. If you are happy with your current plan, you don't need to do anything. Your plan will continue into the next year.

Selecting a new doctor — who to choose and knowing what is covered by your insurance plan

Many people find that the open enrollment period for their insurance plan is also a good time to reassess their preferred doctor. Others, however, like and want to stay with their current doctor, but need to change insurance plans. How do you know if you can keep your current doctor or not? If you decide to change, how do you select a new doctor? When looking for a new doctor, you should consider your insurance plan's in-network list of providers, your personal preferences, and the referrals of others.

Seek referrals from others

For many, it might be easiest to begin by seeking referrals. Ask your friends, family members, and others who they prefer for their medical care and why. Do they feel that all of their needs are met by their provider? Would they recommend that you see the provider as well? Compile a list of several names, then consult your health plan to see if these doctors are in the plan's network. There is no sense pursuing care from providers not in-network unless you have very good reason for doing so and aren't concerned about out-of-network costs. In-plan providers will generally always cost less than out-of-network physicians, and for some plans, such as CarePoint Advantage, some in-network doctor's visits, such as primary care visits, have a $0 co-pay, meaning you pay nothing out-of-pocket for the visit if it is Medicare-eligible.

Narrow down your list

After you have compiled a list of doctors and verified that they are covered by your plan, begin narrowing down that list. Find out how far away the providers are from your home. For most, closer is better. In addition, you will want to find out where your provider has hospital privileges or prefers to send patients for hospital services. Convenience is an asset when you are injured or ill.

If you have a preferred hospital, does your plan cover care at that facility and does your preferred doctor have privileges there? If you are hospitalized, do you want your doctor to be the one to admit you and care for you, or are you ok with the hospital's providers (usually called "hospitalists") providing your care? Next, narrow your list even further by determining the following:

- **Is there enough parking or public transportation nearby?**
- **How far is it from parking to the office, and is assistance available if you use a wheelchair, walker, or need help getting from your car into the office?**
- **What hours does the office keep? What if you need evening or weekend care — who will provide that help?**
- **Is there someone to call after hours? Are they part of the practice or someone the office contracts with?**
- **If x-rays, lab tests, or other studies are required, do they take place in the office, or do you need to go elsewhere (an outside lab, radiology center, etc.)?**
- **How easy is it to get an appointment? What if you have an urgent need? Can you be seen the same day?**
- **When calling or visiting the office, is the staff friendly, courteous, and professional?**
- **How long does it take to get a return phone call and who answers if you call them? If you leave a message, who returns the call — your doctor, a nurse, someone else?**

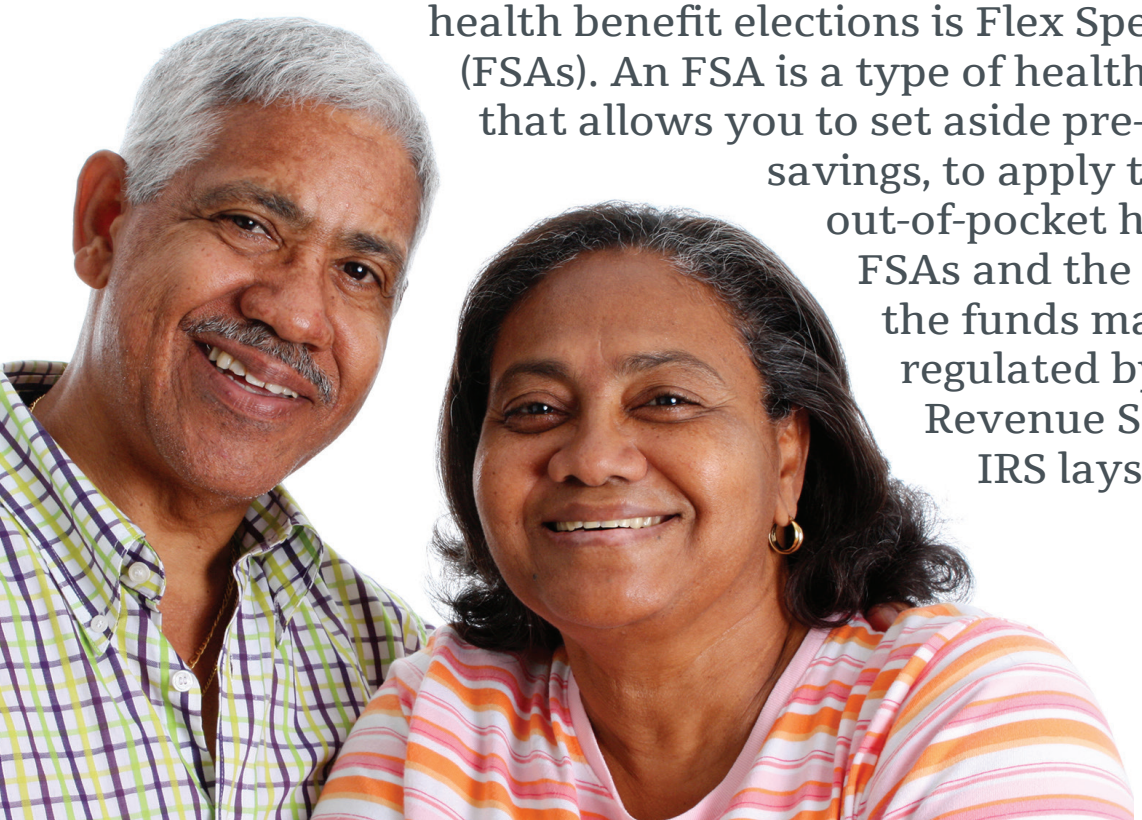
Does the provider also perform specialty exams and services such as gynecology? Do you need a specialist in addition to your primary care doctor?

Is the doctor's age or gender important to you?

Do you want a doctor who acts as a leader, making decisions for you, or a doctor who is a collaborator and acts as a teammate in decision making?

Determining the answers to these questions should help you narrow your list of choices significantly. Ultimately, you need to be comfortable with your chosen doctor. You should trust your provider with your care and your privacy, and you should feel comfortable approaching him or her with any health issue, no matter how big or small.

Making use of flex dollars and other health care funds



One final consideration this year when planning your health benefit elections is Flex Spending Accounts (FSAs). An FSA is a type of health savings plan that allows you to set aside pre-tax dollars, or savings, to apply towards your out-of-pocket healthcare costs. FSAs and the way in which the funds may be used are regulated by the Internal Revenue Service (IRS). The IRS lays out rules for

how, when, and why these funds may be used towards your medical expenses, and these rules are quite strict. It is important to follow the rules to ensure that you get the most out of your flex dollars or other health care funds.

How FSAs work

With an FSA, you pay for the cost of certain health care needs up front, then file a claim for reimbursement. It is important to understand that you can use your FSA funds or some other funds to pay for these expenses, but not both. Any items reimbursed by FSA funds may not be reimbursed with any other plan. Your FSA has a "plan year" — a start and end date, and the funds must be used within that year. Be sure to keep receipts or any other documentation that may be necessary to support your reimbursement claim as you will need to submit this documentation with your reimbursement requests.

Plan carefully for the coming year

When electing your health coverage and setting up an FSA, usually through an employer — either yours or your spouse's — take time in planning the amount of money you wish to set aside to cover upcoming health-related expenses. Your election amount cannot be changed once the plan year starts unless you have a qualifying life-changing event. Make a reasonable estimate for the amount you will need reimbursed over the course of the year, but be cautious to not overestimate this amount, as you can't get back any unclaimed or unused amounts.

Add up the cost of your average medical expenses for a typical month and multiply that number by 12 to estimate the total for the year. Now, add to that the cost of any annual or semi-annual expenses such as vision exams or dental care. Be sure to include the cost of co-pays, prescription medications, hearing aids, etc.

Be sure the expenses you want covered are acceptable by the IRS

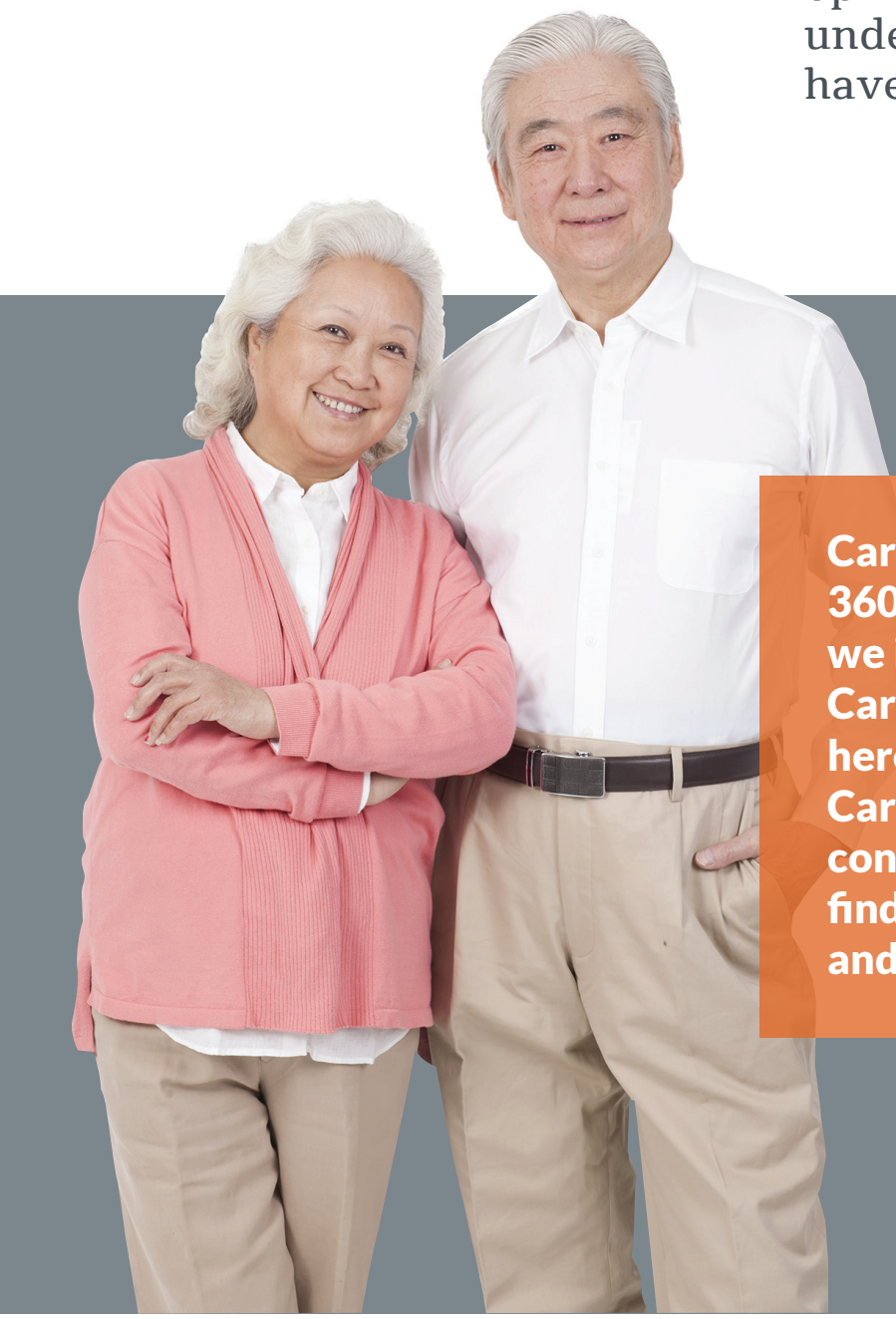
The IRS keeps a lengthy list of acceptable health care costs with explanations of each on their website in IRS Publication 502. In general, you may claim expenses such as doctor's office and hospital co-pays, prescription drug co-pays, health plan deductibles, preventive dental exams including cleanings and x-rays, vision care costs, and a large number of other medical and health care expenses. You may even use flex dollars to pay for plan deductibles for Medicare and Medicare Advantage health plans, although you may not use these funds to pay plan premiums.

Use it or lose it

It is important to not overestimate your FSA expenses since you won't be able to get back any amounts you don't claim for reimbursement. Rollovers to the next year aren't allowed, and thus any funds left over will be lost to you.

Seek out guidance and answers

Although this guide has provided a general overview of many of your Medicare-related health insurance options and related topics, we understand that you may still have questions.



CarePoint Health is proud to offer 360-degree coordinated care, and we invite you to get in touch. Our CarePoint Plans Specialists are here to answer your Medicare and CarePoint Advantage questions and concerns. We want to help you to find and obtain the best health plan and services for your needs.

Please call us today at 1-855-593-5757 or visit us at www.carepointadvantage.org

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